PREADMISSION SCREENING (PAS) / ANNUAL RESIDENT REVIEW (ARR)

(Mental Illness / Developmental Disability Identification)

☐ **PAS**
☐ **ARR**
☐ **Significant Changes**

SECTION I – Patient, Guardian, and Agency Information:

Patient Name (First, MI, Last)			Date of Birth (M,D,Y)	Gender ☐ **Male** ☐ **Female**
Address (Number and Street)			County of Residence	Social Security Number
City	State	ZIP Code	MEDICAID Beneficiary ID Number	MEDICARE ID Number
Does this patient have a court-appointed guardian or other legal representative? ☐ **NO** ☐ **YES** ▶			If YES, Give Name of Guardian or Legal Representative	
County in which the Guardian was Appointed			Address (Number, Street, Apt. Number or Suite Number)	
Guardian or Legal Representative Telephone Number ( ) –			City	State / ZIP Code
Referring Agency Name			Telephone Number ( ) –	Admission Date (Actual or Proposed)
Nursing Facility Name (Proposed or Actual)			County Name	
Facility Address (Number and Street)			City	State / ZIP Code

INSTRUCTIONS:

- Sections II & III of this form must be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or a physician.
- Answer **ALL SIX (6)** items below.
- The person screened shall be determined to require a comprehensive **Level II OBRA** screening if any of the items 1 thru 6 are answered "YES" **UNLESS** a physician certifies on form DCH-3878 that the person meets at least one of the exemption criteria.
- If you check "YES" to items 1 and/or 2 in **Section II** below, circle the word "**mental illness**" or "**dementia**".

SECTION II – Screening Criteria: *(See the copy distribution in the Instructions.)*

1. ☐ NO ☐ YES..... The person has a current diagnosis of MENTAL ILLNESS or DEMENTIA. ***(Circle One)***
2. ☐ NO ☐ YES..... The person has received treatment for MENTAL ILLNESS or DEMENTIA within the past 24 months. ***(Circle One).***
3. ☐ NO ☐ YES..... The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days.
4. ☐ NO ☐ YES..... There is presenting evidence of mental illness or dementia including significant disturbances in thought, conduct, emotions, or judgment.
5. ☐ NO ☐ YES..... The person has a diagnosis of a developmental disability including, but not limited to, mental retardation, epilepsy, autism, or cerebral palsy.
6. ☐ NO ☐ YES..... There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have mental retardation or a related condition.

Explain any "YES"

SECTION III – CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate.

Clinician Signature Date			Name (Typed or Printed)
			Degree / License
Address (Number, Street, Apt. Number or Suite Number)			
City	State	ZIP Code	Telephone Number ( ) –

DCH-3877 (06/03) Replaces form MSA-3877, which is obsolete.

Instructions for completing form DCH-3877
Mental Illness / Developmental Disability Identification Criteria

LEVEL I SCREENING: Completing the DCH-3877

The DCH-3877 is used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or developmental disability and who may be in need of mental health services. This form must be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or physician.

Preadmission Screening: The DCH-3877 must be completed by hospitals as part of the discharge planning process or by physicians seeking to admit an individual to a nursing facility from other than an acute care setting. **Check the PAS box.**

Annual resident review: The DCH-3877 must be completed by the nursing facility. **Check the ARR box.**

1. **Mental Illness:** A current primary diagnosis of a mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV).
   Current Diagnosis means that a physician has established a diagnosis of a mental disorder within the past 24 months. Do NOT mark "YES" for an individual cited as having a diagnosis "by history" only.
2. **Receipt of treatment for mental illness or dementia within the past 24 months** means any of the following: inpatient psychiatric hospitalization; outpatient services such as psychotherapy, day program, or mental health case management; or referral for psychiatric consultation, evaluation, or prescription of psychopharmacological medications.
3. **Antidepressant and antipsychotic medications** mean any currently prescribed medication classified as an antidepressant or antipsychotic, plus Lithium Carbonate and Lithium Citrate.
4. **Presenting evidence** means the individual currently manifests symptoms of mental illness or dementia, which suggest the need for further evaluation to establish causal factors, diagnosis and treatment recommendations.
5. **Developmental Disability:** An individual is considered to have a severe, chronic disability that meets **ALL** four of the following conditions:
   a) It is manifested before the person reaches **age 22**.
   b) It is likely to continue indefinitely.
   c) It results in substantial functional limitations in **three or more** of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.
   d) It is attributable to:
      - mental retardation such that the person has significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period;
      - cerebral palsy, epilepsy, autism; or
      - any condition other than mental illness found to be closely related to mental retardation because this condition results in impairment in general intellectual functioning OR adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons.

6. **Presenting evidence** means the individual manifests deficits in intellectual functioning or adaptive behavior, which suggests the need for further evaluation to determine presence of a developmental disability, causal factors, and treatment recommendations.

NOTE: When there are one or more "YES" answers to questions 1 – 6 under SECTION II, a DCH-3878 must be completed only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or exempted hospital discharge.

AUTHORITY:	P.A. 280 of 1939	The Department of Community Health is an equal opportunity employer, services, and programs provider.
COMPLETION:	Is Voluntary, but is required if Medical Assistance program payment is desired.	

DISTRIBUTION:

If any answer to questions 1 – 6 in SECTION II is "YES," do the following:

- Send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested.
- The nursing facility must retain the original in the patient record and see that a copy goes to the patient or authorized patient representative.